International Journal of Mental Health Nursing

The group was the only therapy which supported my needs, because it helped me feel normal and I was able to speak out with a voice': A qualitative study of an integrated group treatment for dual diagnosis service users within a community mental health setting.

Journal:	*International Journal of Mental Health Nursing*
Manuscript ID	IJMHN-2019-090.R2
Manuscript Type:	Original Article
Keywords:	Dual Diagnosis, Mental health, Integrated treatment, Service users, Substance misuse, Qualitative

Abstract:

Whilst the evidence for the efficacy of treatment interventions for individuals with dual diagnosis has been developing in recent decades, little is known about individual perceptions and the personal benefits of attending integrated treatment programmes within this population group.

A qualitative methodology, Interpretive Phenomenological Analysis, was used to investigate the experiences of individuals with a range of complex mental health and co-existing substance misuse problems who took part in a Psychoeducational Group (PEG) Programme. This comprised of social support and therapeutic peer group relationship facilitation. Semi structured interviews were undertaken with 15 service users who successfully participated in this treatment Programme.

Findings identify the complexity of the therapeutic process and understanding of the treatment from the service users perspective. This included the importance forming meaningful therapeutic relationships as an influential factor in countering a range of distressing and incompatible environmental and situational stressors, such as self-regulatory control, self-awareness of a need for change and the importance of integrated treatment in reducing the sense of stigma and exclusion linked with using mental health services.

The study findings support the use of integrated treatment programmes in mental health services with a dual diagnosis population group.

SCHOLARONE™
Manuscripts

Title: '*The group was the only therapy which supported my needs, because it helped me feel normal and I was able to speak out with a voice'*: A qualitative study of an integrated group treatment for dual diagnosis service users within a community mental health setting.

For Review Only

Abstract

Whilst the evidence for the efficacy of treatment interventions for individuals with dual diagnosis has been developing in recent decades, little is known about individual perceptions and the personal benefits of attending integrated treatment programmes within this population group.

A qualitative methodology, Interpretive Phenomenological Analysis, was used to investigate the experiences of individuals with a range of complex mental health and co-existing substance misuse problems who took part in a Psychoeducational Group (PEG) Programme. This comprised of social support and therapeutic peer group relationship facilitation. Semi structured interviews were undertaken with 15 service users who successfully participated in this treatment Programme.

Findings identify the complexity of the therapeutic process and understanding of the treatment from the service users perspective. This included the importance forming meaningful therapeutic relationships as an influential factor in countering a range of distressing and incompatible environmental and situational stressors, such as self-regulatory control, self-awareness of a need for change and the importance of integrated treatment in reducing the sense of stigma and exclusion linked with using mental health services.

The study findings support the use of integrated treatment programmes in mental health services with a dual diagnosis population group.

For Review Only

KeywordsDual Diagnosis, mental health, substance misuse, qualitative, service users, integrated treatment.

Declaration of interest

None declared.

For Review Only

Main text

The term dual diagnosis spans a diverse range of mental health and substance misuse problems that an individual can experience concurrently (NICE, 2016). The nature of, and relationship between both dimensions of problems vary and change over time, and can be manifest in poor engagement with treatment services, non-adherence to prescribed medication and worsening prognosis (Gobbart, 2013). Therefore, an understanding of the complexities of co-occurring conditions is critical for effective treatment (Barrowclough et al., 2010).

Substance misuse among psychiatric spectrum disorders is widespread (NICE, 2016), and current estimates in the United Kingdom (UK) suggest that a third of service users with serious mental illness have a substance misuse problem, and up to half of individuals with substance misuse have an active mental health problem (Public Health England, 2017). Furthermore, active substance misuse among individuals with a psychiatric disorder has been associated with significantly poorer outcomes, making treatment provision problematic and predictably lengthier (Parrish, 2014).

The treatment profiles of service users with dual diagnoses are not always straightforward or linear in nature. Similarly, treating each condition independently of each other by different service providers is challenging, since the two conditions are not mutually exclusive (Taylor and Kliewer, 2006). Nevertheless, irrespective of these complexities, an integrated multimodal treatment approach is considered efficacious (Kay-Lambkin et al., 2009). This approach enables health care professionals an opportunity to utilise a range of beneficial therapeutic approaches to enhance treatment outcome. These might include motivational enhancement therapy, cognitive behavioural therapy, relapse prevention and psychoeducation interventions (Cleary et al., 2008).

For Review Only

Furthermore, research using an integrated approach has found valuable treatment outcomes for service users with dual disorders who completed psychotherapeutic group treatment programmes, e.g. reduced symptomatology, reduced substance misuse and increased adherence to treatment intervention (Gobbart, 2013, Chilton et al., 2018). Gobbart (2013) concluded that their treatment approach augmented participants' existing resources and galvanised their sense of trust and hope within an integrated care pathway, thus enhancing their individual resilience and adherence to treatment.

Whilst integrated approaches that combine mental health and substance misuse treatment have been seen to be effective (Chilton et al., 2018, Gobbart, 2013); the accounts of service users receiving such treatment remains scarce. In response to this, the current study investigated service users experiences of an integrated, psychoeducational group (PEG) therapy, designed to treat individuals with mental health and substance use disorders within an integrated delivery system. Specific details of the programme have been presented elsewhere (Chilton et al., 2018) but in summary it was designed upon principles of best practice (NMC, 2018) to enhance mental well-being and concordance. To understand more about the individual experiences of this client group, Interpretive Phenomenological Analysis (Smith, 2011) with semi-structured interviews was used to explore subjective experiences and perceptions of the therapeutic process.

Methods

The PEG treatment programme was developed as a partnership outreach project between local mental health and substance misuse service providers to enhance service delivery for dual diagnosis services users. The programme is based around psychoeducational, harm-reduction, motivational and goal setting techniques that were adapted from a recovery-based dual diagnosis

For Review Only

treatment manual (Derry, 2008). The PEG therapy model aimed to increase participants' capacity to change their pattern of substance misuse and provide relevant information concerning aspects of their mental and physical well-being. Treatment comprised of 10 weekly 2-hour sessions per group. The maximum size of each group was set at 12 participants' to ensure that it was large enough to enable all involved to engage effectively (Morgan and Carson, 2009). Eight programmes were completed during the 18-month period of evaluation. Furthermore, the study received ethical approval by the regional National Health Service Ethics Committee (NHSEC) and host Mental Health Trust.

The overarching aim of the study was to explore the individual experiences of participants with dual-diagnosis undertaking a group treatment intervention. Nine male and six female participants were purposively recruited for the study. Eligibility to be invited to take part was based on a diagnostic assessment for serious mental illness as well as substance misuse related diagnoses. Participants were also required to be able to read and speak English to the level necessary for completion of informed consent procedures and to participate meaningfully in group discussions and completion of the programme. Health care professionals responsible for the overall care of dual-diagnosis clients were requested to identify suitable participants who had completed the treatment programme, who t could be approached to participate in a pre-interview to discuss participation in the more in depth, semi-structured interviews. Individuals who undertook a pre-interview were provided with all the necessary information concerning the study and any outstanding queries regarding the study clarified. Table 1 provides an overview of the 15 participants who took participated in this qualitative investigation.

Table 1 here.

For Review Only

Once consent to take part was provided, participants were offered the opportunity to conduct the interview in their own home or at a nominated mental health resource centre within their local community. Semi-structured interviews were employed to allow the participant to communicate more freely about their experience of being involved in PEG therapy (Reid et al., 2005). An interview schedule aided the interview process which was developed based upon the aim of the investigation. Example questions from the schedule included 'what are your thoughts about the treatment programme?'; 'can you tell me how you felt whilst you were participating?' and 'have you experienced what you expected?' Interviews were recorded and transcribed, with computer assisted qualitative software N-Vivo-8 (Bazeley and Jackson, 2013) used to store the data and manage the analysis process. In accordance with Interpretive Phenomenological Analysis (Smith, 2011), transparency of the analysis process was assured through XXXX. reflexivity. This was supported by the maintenance of a journal to record participant interview observation, overall impressions of the treatment process and aid the researcher to 'bracket off' (Smith, 2011) personal assumptions, beliefs and presuppositions during the entirety of the study period, a necessary position when employing interpretative phenomenology. Anonymity and confidentiality of participants was protected at all times with the use of pseudonyms.

Results

The properties of the themes reflected the duality of personal subjective experiences of living with dual diagnosis and the multidimensional properties of the therapeutic process. Themes are presented in Table 2 and described with quotations from the transcripts to provide service user's

For Review Only

lived experiences through their own voices. Quotations are presented with the participant's pseudonym and the line number from the interview transcript.

Table 2 here.

Dual Relationship with Illness

This theme encompassed characteristics of bio-psychosocial distress, comprising of complex levels of symptomatology that limited an individuals' personal recovery. The relationship that substance misuse had alongside distressing symptoms of mental health conditions was evident on a number of contextual levels. These included participants' ability to use substances as a means of diminishing their subjective experience of symptomatic distress, or believing that chronic or sustained levels of substance misuse had additional benefits, such as improving personal and social well-being in the context of the peer group experience. Participants' subjective experiences oscillated around issues of managing denial and the impact this behaviour had on developing and maintaining relationships alongside a sense of belonging. These relationships had a beneficial effect on social acceptance, comprised of coping with painful memories of childhood trauma. In turn these antecedents and underlying social reinforcing factors acted on participant's internal locus of control (Lefcourt, 2014), and personal attributes of motivational behaviour (Miller and Rollnick, 2012);

'Not being able to say no to drugs is a problem, as I thought drugs helped me cope with life, and hoping it would take the pain away' (David).

For Review Only

The factors effecting individuals' perception of their complex condition reflected the idiosyncratic nature of substance misuse and individuals' ability to make salient choices regarding their dependency on drugs. There was a recognition that the process of self-medicating with particular substances, such as alcohol and cannabis, had a self-regulatory effect upon participants' mental health condition, thus supporting the self-medication theory (Khantzian, 1987). The phenomena of self-medication became a conduit as a way coping with side effects associated with prescribed psychiatric medication treatments;

'I have been self-medicating for years with alcohol and drugs. I have always had problems with dealing with my problems such as anxiety and depression, and it has made me really scared over the years. I don't like the shakes from my prescribed tablets, but I do have cannabis and alcohol to help me cope with the difficulty times in my life, as my problems bring me down all the time' (Alexi).

Exposing these aspects of experiential knowledge provided participants' with the ability to view causal mechanisms and consequences of individual behaviour as an organic and incremental process of change. Participants' accumulated an array of negative experiences in relation to their co-morbid condition, often resulting in a variety of maladaptive developmental responses. However, participants attempted to make sense of their maladaptive behaviour and complex case histories;

'Drinking is the thing that I use to help me with my bad experiences and anxiety over time. The way I feel has never stayed the same, it just depended on the bad circumstances which have affected me over the years at given points in time' (Spencer).

For Review Only

Participants' ability to interact with their social environment was a crucial factor in acknowledging and redefining their dual disorder in the context of their dependent behavioural patterns.

Levels of knowledge

This theme revealed a number of gaps in participants' level of knowledge of how to manage their substance misuse effectively. Participant's reported, for example, stimulant drug use as a means to address symptoms of mood disturbance without taking into account the consequences of associated rebound effects. However, the short and long-term effects of substance misuse resulted in a range of unpleasant emotional and psychological experiences such as anxiety, exhaustion; problems with volition, motivation and paranoia. Participants described their limited understanding concerning the consequences of their substance misuse and the interactive effects of their prescribed medication;

'I did not know that alcohol had such a massive depressing effect on my mental health, especially as I thought the prescribed antidepressant from my doctor was helping me cope with my mood' (Gary).

This dual conflict of independence versus dependence was common place and demonstrated a dichotomy between the needs of the individual and the treatment perspective; traditionally based on prescriptive models of practice (NICE, 2016). Participants' expressed a degree of uncertainty concerning the longitudinal negative effects of their substance misuse and described their ongoing relationship with drugs as a form of personal reassurance and affiliation with a familiar behaviour (Cassidy et al., 2013). This comprised of personal levels of attachment by participants' via cyclical and reinforcing methods of substance misuse. Some described their ongoing

For Review Only

relationship with substance misuse as if it were a co-dependent emotional attachment, dysfunctional in nature, often associated with the ebb and flow of the tide (Buchanan-Barker and Barker, 2008);

'I think at times my drug use changed week on week and it is just like kicking the cat which stirs up so many emotions in a very unstable way. The group helped me make sense of some of these emotions' (Emily).

'The group made sense because it combined useful information about mental health and substance misuse. It was done in a way that made me feel supported' (Stacey).

Getting started on alcohol and drugs

This theme explained the complex factors associated with commencing substance misuse. Traumatic or stressful life events were commonly cited as a precursor to drug use, contributing to individuals becoming increasingly vulnerable and experiencing long-term comorbidity (Chartier et al., 2009). The repeated misuse of illicit substances in response to environmental stressors and increasing levels of vulnerability, revealed a pattern of escalating drug use;

'There were a number of circumstances that contributed to my drinking behaviour. I started drinking at 12 and then I lost my brother in a car accident and things just got worse' (David)

For some participants the description of trauma related to experiences in early childhood was related to a marked decline in their mental well-being and quality of life which was manifest in a variety of mental health symptoms and maladaptive addictive behaviours (Romme and Escher, 2013);

For Review Only

'I was always having strange dreams regarding my abusive childhood. It got to the stage when I was drinking heavily, and the voices became really loud and negative and I got worse mentally. But it got to the stage when the voices were just there all the time telling me I was to blame no matter what I did and this just made me drink even more' (Greg;).

The implication of such psychopathology was dependent on some participant's individual circumstances and social learning experiences. Many participants' started consuming drugs and alcohol at a young age, resulting in some participants escalating from occasional use to more problematic dependency and tolerance to stronger drugs (Zernig et al., 2013). For many participants this engendered a sense of helplessness and hopelessness, typically reinforced by poor and dysfunctional social networks, often leading to chronic periods of social isolation, stigma and depersonalisation.

Impact of Condition on Behaviour and Lifestyle

This theme explains participants' aspiring to change aspects of their behaviour and lifestyle along with personal insight regarding the negative impact substance misuse played in their lives;

'I was taking too many drugs which made me unhappy and paranoid. I did a lot of stupid things. I did not talk to many people, keeping myself to myself. I could just not understand why I was seeing people in the way I was, and hurting people who were close to me. My life did not make much sense and I struggled for years' (Stuart).

For Review Only

For some participants' there was a sense that something could be done to suspend or reverse the consequences of their maladaptive behaviour by acknowledging the beneficial component of peer support and engaging in the treatment process;

'My drug use was a big problem and I just wanted to get more control in my life and that is why I wanted to speak to other users in the group therapy who understood my problem. By being with others in the group who understood my problem it helped feel safe and think about my own situation and how it affected my relationship with my family and especially my daughter' (Will).

However, treatment did not necessarily result in positive change or perceived social benefits. It was acknowledged that sometimes it can be difficult to socialise with others, being caught up in a duality of despair, often resulting in social isolation, dysfunctional relationships, and ongoing poor engagement with mental health services reinforced over many years (Drake et al., 2006).

Motivation to Change

This theme included a focus upon taking action to change behaviour. Change was supported by motivation, which manifested in individual actions orientated towards modifying maladaptive and harmful behaviours. However, it was clear that some participants were at different stages in their recovery journeys, with a sense of hopefulness being a central component to the treatment process (Bonney and Stickley, 2008)

'There is a huge link regarding my mental health and drug use. I have been thinking about changing my life around for a long time. Coming to the group allowed me to make a positive jump forward. But you need the right kind of help and the right kind of information to make meaningful changes' (Stacey).

For Review Only

Some participants displayed a level of self-awareness and readiness to change that resonated in their experience of the treatment process. Consolidating and maintaining changes was an important consideration acknowledged by participants. This factor is relevant as stages of motivation often comprise of cyclical episodes of relapse and remission (Kazdin, 2009). Participants demonstrated elevated levels of motivation which often emerged after considerable self-reflection reinforcing individual's ability to consolidate positive and meaningful change;

'I am more aware, because we talked about taking control in the group and looking back I think I was planning things in my life but I just was not aware of it. The ability to think positively about change with others in the group gave me the confidence to consider moving forward' (Lara).

Many participants' regardless of their level of motivation required meaningful and cohesive support. The level of self-perception concerning social support with other people with the same sort of problem encapsulated collective, not singular social intervention. Consequently, the process of motivation to change resulted in, and their constant struggle for, control of their condition;

'I was not sure about the group and how motivated I was to work with others in the group. I am still using drugs and will not stop, but it did make me think about the risks and harm in my life. Drug use is risky and many of my mates have died using drugs' (Gary).

Struggle for Control of Treatment

This theme explored the myriad of challenges faced by participants' in relation to their treatment and the level of autonomy they experienced as recipients of mental health service provision. Prescribed psychiatric medication management was referred to frequently, with a variety of

For Review Only

views being stated concerning the efficacy of treatment. Causal mechanisms and poor standard treatment outcomes were frequently highlighted as primary reasons for participants' continuing to use illicit substances. The medical model (Hirschkorn and Bourgeault, 2007) was also deemed limited in its prescriptive scope and level of effectiveness to deal with participants' complex needs. Many participants' experienced challenges in self-managing and self-regulating their prescribed psychiatric drug treatment;

'I am on prescribed medication from the doctor, but I still have problems with voices and many side-effects of the medication like twitches and muscle stiffness. I have used a bit of cannabis to help with some of the side-effects, but I have not told the consultant psychiatrist because he would not understand' (Gary).

The struggle for control of the treatment process by participants was conceptualised as an ongoing dialogue with treatment services to reduce the perceived negative impact of specific treatments. All participants' were being prescribed psychiatric medication as part of their ongoing mental health condition, and were expressed in association with attempting to self-manage their prescribed medication and illicit substance misuse;

'The new mental health drug kind of helps my hearing voices, but it does make me very drowsy. When I have taken heroin and in the past many of my voices do go away but it can cause problems with my prescribed treatment. It can be a double bind at times' (Tony).

Communication with Others

For Review Only

Some participants' described the inclusive treatment process as a means of amplifying a sense of humility and empathy (Barker and Buchanan-Barker, 2004). Thus enabling active engagement with other group members, directly placing responsibility for their interaction to change their behaviour within the sphere of their control;

'I think sharing experiences with others was really important. If you talk to people you can have a sort of conversation and you bond with them. It can give you a sense of belonging and feeling normal because they understand where you are coming from. I also think it is the help you get through communication with others that really counts' (Kay).

Group members shared similar problems with each other, and were able to help one another, on the same level, i.e. peer to peer. Some participants recognised their own emotional state and that of others in the group, enabling them to value and validate fellow members within a process of reciprocity and reflect on the importance of past experiences.

'The group was the only therapy which supported my needs because it helped me feel normal and I was able to speak out with a voice' (Margarete).

The interpersonal and cohesive structure of the group programme was directly linked to individual perception and a sense of belonging and needing to affiliate of members to a supportive treatment intervention that validated the individual and the collective experience.

Participants' stressed the importance of effective communication and connecting with others. However, for some the treatment process identifies some challenges in forming and maintaining meaningful social relationships, generally;

For Review Only

'I have been blamed for my drug use ever since I was in my adolescence. You might say that I have deserved it. But it is just how my life has been which makes it difficult to connect' (Jacob).

The level of personal distress and the importance of personal attributes, such as trust and honesty, were perceived as important when forming beneficial relationships within a social context (Link and Phelan, 2013).

Sense of Belonging

This theme reflected the essence of the therapeutic group intervention and the opportunity it provided for participants to interact successfully with other group members; reinforcing a sense of self-identity and belonging to the treatment intervention. Participation itself and appreciation of being accepted unconditionally by other group members, with similar co-occurring conditions, had a regulatory effect on their negative experiences. This in turn supported some individuals to externalise the maladaptive characteristics of their behaviour and contextual perspectives of the treatment process;

'I have been in and out of treatment for years being passed from one service to another. The group helped me work through my problems and I felt accepted and part of something worthwhile and I felt accepted and part of something whole' (Stuart).

Participants stated they valued the experience of social inclusion and participation in the decision-making process concerning their health care provision which contrasted with their pervading sense of social exclusion and perceived stigma from mental health services and society at large, which they had endured over many years;

For Review Only

'I have experienced a lot of negative attitudes by other people over many years, who have blamed me for things that were not my fault, often not knowing who I was as a person or taking the time to ask' (Robert).

'Because we had similar problems and backgrounds in the group I felt more confident to express my-self and because we all had something wrong with us it kind of made us stronger in a strange way' (Lara).

The findings of the study suggest that providing integrated treatment for mental health and substance misuse through the use of PEG therapy proved beneficial across both dimensions of problems presented by people with dual diagnosis. Importantly, participants' reported finding the formation of meaningful therapeutic relationships within the group to be an important factor in their experiences. The idiosyncratic nature of these relationships has been characterised as a means of countering a range of distressing and incompatible environmental and situational stressors, such as poor levels of symptom control and social anxiety (Chaplin et al., 2008). The importance of developing a sense of balance and perspective by participants' in PEG therapy was considered crucial to reducing participants' situational stressors and negative social influences consistent with poor service fidelity, high levels of relapse, stigma and escalating levels of social neglect and conflict (Walker et al., 2013).

Participants' reported finding the integration of treatment to be beneficial in reducing the sense of stigma and exclusion linked with using mental health services (Minkoff, 2013). Effective treatment plans need to address the role played by single treatment delivery systems, and the effective application of holistic treatment approaches need to be considered an important aspect

For Review Only

of treatment for individuals with complex comorbid conditions (NICE, 2016). It is important to highlight that although the conclusions from this study cannot be generalised, the findings have provided important insights into the therapeutic process through the consideration of the complex interactions of service user experience and the curative dynamics of the treatment process.

The study had a number of limitations. For example, the term dual diagnosis is broad and non-specific, and whilst it is used frequently to describe a service user group, it is of little value when tailoring individual care or treatment. There is a danger of contributing to the homogenising effect through the use of this label. In terms of participants, the study was constrained by a possible a self-selection bias in the participant sample and the applied, in-practice nature of the study design.

Relevance to clinical practice

Integrated treatment for dual diagnosis, where the mental illness and the substance use disorder are treated simultaneously, is a developing approach in clinical care. This study provides further insight into the efficacy of such approaches by providing qualitative findings to complement the existing, yet sparse, evidence base. Understanding the dynamics of these treatment approaches, such as the important role of social integration and the provision of a social network for discussions with similar others, are useful factors for health care professionals to consider in the future design and delivery of treatment for dual diagnosis.

For Review Only

References

Barker, P. J. & Buchanan-Barker, P. (2004). *The Tidal Model: A guide for mental health professionals*: Routledge.

Barrowclough, C., Haddock, G., Wykes, T., et al. (2010). Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: randomised controlled trial. *BMJ,* 341**,** c6325.

Bazeley, P. & Jackson, K. (2013). *Qualitative data analysis with NVivo*: Sage Publications Limited.

Bonney, S. & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of psychiatric and mental health nursing,* 15**,** 140-153.

Buchanan-Barker, P. & Barker, P. (2008). The Tidal Commitments: extending the value base of mental health recovery. *Journal of Psychiatric Mental Health Nursing,* 15**,** 93-100.

Cassidy, J., Jones, J. D. & Shaver, P. R. (2013). Contributions of attachment theory and research: A framework for future research, translation, and policy. *Development and psychopathology,* 25**,** 1415-1434.

Chaplin, T. M., Hong, K., Bergquist, K. & Sinha, R. (2008). Gender differences in response to emotional stress: an assessment across subjective, behavioral, and physiological domains and relations to alcohol craving. *Alcoholism: Clinical Experimental Research,* 32**,** 1242-1250.

Chartier, M. J., Walker, J. R. & Naimark, B. (2009). Health risk behaviors and mental health problems as mediators of the relationship between childhood abuse and adult health. *American Journal of Public Health,* 99**,** 847-854.

Chilton, J., Crone, D. & Tyson, P. (2018). Clinical Outcomes From a 10-Week Follow-Up Psychoeducational Program for Dual Diagnosis. *Journal of dual diagnosis***,** 1-9.

Cleary, M., Hunt, G. E., Matheson, S., Siegfried, N. & Walter, G. (2008). Psychosocial treatment programs for people with both severe mental illness and substance misuse. *Schizophrenia Bulletin,* 34**,** 226-228.

Derry, A. (2008). The clinical response to substance use problems in forensic mental health services. *British Journal of Forensic Practice,* 10**,** 20-23.

Drake, R. E., Becker, D. R., Goldman, H. H. & Martinez, R. A. (2006). Best practices: The Johnson & Johnson—Dartmouth community mental health program: Disseminating evidence-based practice. *Psychiatric Services,* 57**,** 302-304.

Gobbart, S. (2013). 'Changing habits': An evaluation of a dual diagnosis focused, integrated, multimodal, psychosocial education and skill building group programme delivered in a community-based setting. *Mental Health and Substance Use,* 6**,** 29-46.

Hirschkorn, K. & Bourgeault, I. (2007). Actions speak louder than words: mainstream health providers' definitions and behaviour regarding complementary and alternative medicine. *Complementary therapies in clinical practice,* 13**,** 29-37.

Kay-Lambkin, F. J., Baker, A. L., Lewin, T. J. & Carr, V. J. (2009). Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: a randomized controlled trial of clinical efficacy. *Addiction,* 104**,** 378-388.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy research,* 19**,** 418-428.

Khantzian, E. J. (1987). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *The cocaine crisis.* pp. 65-74). Springer.

Lefcourt, H. M. (2014). *Locus of control: Current trends in theory & research*: Psychology Press.

For Review Only

Link, B. G. & Phelan, J. C. (2013). Labeling and stigma. *Handbook of the sociology of mental health.* pp. 525-541). Springer.

Miller, W. R. & Rollnick, S. (2012). *Motivational interviewing: Helping people change*: Guilford press.

Minkoff, K. (2013). Treating Comorbid Psychiatric and Substance Use Disorders. *Psychiatric Times,* 30**,** 13-13.

Morgan, S. & Carson, J. (2009). The Recovery Group: A service user and professional perspective. *Group-work,* 19**,** 26-39.

NICE (2016). Coexisting severe mental illness and substance misuse: community health and social care services. London: National Institute for Health and Clinical Excellence.

NMC (2018). The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associate. London: Nursing and Midwifery Council.

Parrish, M. (2014). *Social work perspectives on human behaviour*: McGraw-Hill Education (UK).

Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers. London: PHE.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience: An introduction to interpretative phenomenological analysis. The Psychologist, 18 (1), 20-23.

Romme, M. & Escher, S. (2013). *Psychosis as a personal crisis: An experience-based approach*: Routledge.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review,* 5**,** 9-27.

Taylor, K. W. & Kliewer, W. (2006). Violence exposure and early adolescent alcohol use: An exploratory study of family risk and protective factors. *Journal of Child Family Studies,* 15**,** 201-215.

Walker, H., Tulloch, L., Ramm, M., et al. (2013). A randomised controlled trial to explore insight into psychosis; effects of a psychoeducation programme on insight in a forensic population. 24**,** 756-771.

Zernig, G., Kummer, K. K. & Prast, J. M. (2013). Dyadic social interaction as an alternative reward to cocaine. *Frontiers in psychiatry,* 4**,** 100.

For Review Only

Table 1 Participant Demographic Profile

Pseudonym	**Gender**	**Age**	**Dual Condition**
Alexi	F	50	Schizophrenia/alcohol use disorder
David	M	32	Depression/alcohol use disorder
Emily	F	46	Schizophrenia/alcohol use disorder
Gary	M	50	Schizophrenia/alcohol use disorder
Greg	M	48	Schizophrenia/alcohol use disorder
Jacob	M	39	Schizophrenia/drug dependence syndrome
Kay	F	57	Bi-polar disorder/alcohol use disorder
Lara	F	47	Depression/drug/alcohol use disorder
Margaret	F	56	Schizophrenia/alcohol use disorder
Robert	M	65	Bi-Polar disorder/alcohol use disorder
Stacey	F	40	Schizophrenia/alcohol use disorder
Stuart	M	39	Schizophrenia/drug dependence syndrome
Spencer	M	29	Schizophrenia/alcohol use disorder
Tony	M	24	Mixed anxiety and depressive/alcohol use disorder
Will	M	47	Mixed anxiety and depressive/alcohol use disorder

For Review Only

Table 2 Emergent themes produced from participants' experiences of PEG therapy

Theme
Dual relationship with illness
Levels of knowledge
Getting started on alcohol and drugs
Impact of condition
Motivation to change
Struggle for control of treatment
Communication with others
Sense of belonging

For Review Only

Title: '*The group was the only therapy which supported my needs, because it helped me feel normal and I was able to speak out with a voice'*~~:~~: A qualitative study of an ~~An i~~integrated group treatment ~~approach~~ for dual diagnosis service users within a community mental health setting~~. A qualitative approach.~~

For Review Only

Abstract

Whilst the evidence for the efficacy of treatment interventions for individuals with dual diagnosis has been developing in recent decades, little is known about individual perceptions and the personal benefits of attending integrated treatment programmes within this population group.

A qualitative methodology, Interpretive Phenomenological Analysis, was used to investigate the experiences of individuals with a range of complex mental health and co-existing substance misuse problems who took part in a Psychoeducational Group (PEG) Programme. This comprised of social support and therapeutic peer group relationship facilitation. Semi structured interviews were undertaken with 15 service users who successfully participated in this treatment Programme.

Findings identify the complexity of the therapeutic process and understanding of the treatment from the service users perspective. This included the importance forming meaningful therapeutic relationships as an influential factor in countering a range of distressing and incompatible environmental and situational stressors, such as self-regulatory control, self-awareness of a need for change and the importance of integrated treatment in reducing the sense of stigma and exclusion linked with using mental health services.

The study findings support the use of integrated treatment programmes in mental health services with a dual diagnosis population group.

For Review Only

KeywordsDual Diagnosis, mental health, substance misuse, qualitative, service users, integrated treatment.

Declaration of interest

None declared.

For Review Only

Main text

The term dual diagnosis spans a diverse range of mental health and substance misuse problems that an individual can experience concurrently (NICE, 2016). The nature of, and relationship between both dimensions of problems vary and change over time, and can be manifest in poor engagement with treatment services, non-adherence to prescribed medication and worsening prognosis (Gobbart, 2013). Therefore, an understanding of the complexities of co-occurring conditions is critical for effective treatment (Barrowclough et al., 2010).

Substance misuse among psychiatric spectrum disorders is widespread (NICE, 2016), and current estimates in the United Kingdom (UK) suggest that a third of service users with serious mental illness have a substance misuse problem, and up to half of individuals with substance misuse have an active mental health problem (Public Health England, 2017). Furthermore, active substance misuse among individuals with a psychiatric disorder has been associated with significantly poorer outcomes, making treatment provision problematic and predictably lengthier (Parrish, 2014).

The treatment profiles of service users with dual diagnoses are not always straightforward or linear in nature. Similarly, treating each condition independently of each other by different service providers is challenging, since the two conditions are not mutually exclusive (Taylor and Kliewer, 2006). Nevertheless, irrespective of these complexities, an integrated multimodal treatment approach is considered efficacious (Kay-Lambkin et al., 2009). This approach enables health care professionals an opportunity to utilise a range of beneficial therapeutic approaches to enhance treatment outcome. These might include motivational enhancement therapy, cognitive behavioural therapy, relapse prevention and psychoeducation interventions (Cleary et al., 2008).

For Review Only

Furthermore, research using an integrated approach has found valuable treatment outcomes for service users with dual disorders who completed psychotherapeutic group treatment programmes, e.g. reduced symptomatology, reduced substance misuse and increased adherence to treatment intervention (Gobbart, 2013, Chilton et al., 2018). Gobbart (2013) concluded that their treatment approach augmented participants' existing resources and galvanised their sense of trust and hope within an integrated care pathway, thus enhancing their individual resilience and adherence to treatment.

Whilst integrated approaches that combine mental health and substance misuse treatment have been seen to be effective (Chilton et al., 2018, Gobbart, 2013); the accounts of service users receiving such treatment remains scarce. In response to this, the current study investigated service users experiences of an integrated, psychoeducational group (PEG) therapy, designed to treat individuals with mental health and substance use disorders within an integrated delivery system. Specific details of the programme have been presented elsewhere (Chilton et al., 2018) but in summary it was designed upon principles of best practice (NMC, 2018) to enhance mental well-being and concordance. To understand more about the individual experiences of this client group, Interpretive Phenomenological Analysis (Smith, 2011) with semi-structured interviews was used to explore subjective experiences and perceptions of the therapeutic process.

Methods

The PEG treatment programme was developed as a partnership outreach project between local mental health and substance misuse service providers to enhance service delivery for dual diagnosis services users. The programme is based around psychoeducational, harm-reduction, motivational and goal setting techniques that were adapted from a recovery-based dual diagnosis

For Review Only

treatment manual (Derry, 2008). The PEG therapy model aimed to increase participants' capacity to change their pattern of substance misuse and provide relevant information concerning aspects of their mental and physical well-being. Treatment comprised of 10 weekly 2-hour sessions per group. The maximum size of each group was set at 12 participants' to ensure that it was large enough to enable all involved to engage effectively (Morgan and Carson, 2009). Eight programmes were completed during the 18-month period of evaluation. Furthermore, the study received ethical approval by the regional National Health Service Ethics Committee (NHSEC) and host Mental Health Trust.

The overarching aim of the study was to explore the individual experiences of participants with dual-diagnosis undertaking a group treatment intervention. Nine male and six female participants were purposively recruited for the study. Eligibility to be invited to take part was based on a diagnostic assessment for serious mental illness as well as substance misuse related diagnoses. Participants were also required to be able to read and speak English to the level necessary for completion of informed consent procedures and to participate meaningfully in group discussions and completion of the programme. Health care professionals responsible for the overall care of dual-diagnosis clients were requested to identify suitable participants who had completed the treatment programme, who t could be approached to participate in a pre-interview to discuss participation in the more in depth, semi-structured interviews. Individuals who undertook a pre-interview were provided with all the necessary information concerning the study and any outstanding queries regarding the study clarified. Table 1 provides an overview of the 15 participants who took participated in this qualitative investigation.

Table 1 here.

For Review Only

Once consent to take part was provided, participants were offered the opportunity to conduct the interview in their own home or at a nominated mental health resource centre within their local community. Semi-structured interviews were employed to allow the participant to communicate more freely about their experience of being involved in PEG therapy (Reid et al., 2005). An interview schedule aided the interview process which was developed based upon the aim of the investigation. Example questions from the schedule included 'what are your thoughts about the treatment programme?'; 'can you tell me how you felt whilst you were participating?' and 'have you experienced what you expected?' Interviews were recorded and transcribed, with computer assisted qualitative software N-Vivo-8 (Bazeley and Jackson, 2013) used to store the data and manage the analysis process. In accordance with Interpretive Phenomenological Analysis (Smith, 2011), transparency of the analysis process was assured through XXXX. reflexivity. This was supported by the maintenance of a journal to record participant interview observation, overall impressions of the treatment process and aid the researcher to 'bracket off' (Smith, 2011) personal assumptions, beliefs and presuppositions during the entirety of the study period, a necessary position when employing interpretative phenomenology. Anonymity and confidentiality of participants was protected at all times with the use of pseudonyms.

Results

The properties of the themes reflected the duality of personal subjective experiences of living with dual diagnosis and the multidimensional properties of the therapeutic process. Themes are presented in Table 2 and described with quotations from the transcripts to provide service user's

For Review Only

lived experiences through their own voices. Quotations are presented with the participant's pseudonym and the line number from the interview transcript.

Table 2 here.

Dual Relationship with Illness

This theme encompassed characteristics of bio-psychosocial distress, comprising of complex levels of symptomatology that limited an individuals' personal recovery. The relationship that substance misuse had alongside distressing symptoms of mental health conditions was evident on a number of contextual levels. These included participants' ability to use substances as a means of diminishing their subjective experience of symptomatic distress, or believing that chronic or sustained levels of substance misuse had additional benefits, such as improving personal and social well-being in the context of the peer group experience. Participants' subjective experiences oscillated around issues of managing denial and the impact this behaviour had on developing and maintaining relationships alongside a sense of belonging. These relationships had a beneficial effect on social acceptance, comprised of coping with painful memories of childhood trauma. In turn these antecedents and underlying social reinforcing factors acted on participant's internal locus of control (Lefcourt, 2014), and personal attributes of motivational behaviour (Miller and Rollnick, 2012);

'Not being able to say no to drugs is a problem, as I thought drugs helped me cope with life, and hoping it would take the pain away' (David).

For Review Only

The factors effecting individuals' perception of their complex condition reflected the idiosyncratic nature of substance misuse and individuals' ability to make salient choices regarding their dependency on drugs. There was a recognition that the process of self-medicating with particular substances, such as alcohol and cannabis, had a self-regulatory effect upon participants' mental health condition, thus supporting the self-medication theory (Khantzian, 1987). The phenomena of self-medication became a conduit as a way coping with side effects associated with prescribed psychiatric medication treatments;

'I have been self-medicating for years with alcohol and drugs. I have always had problems with dealing with my problems such as anxiety and depression, and it has made me really scared over the years. I don't like the shakes from my prescribed tablets, but I do have cannabis and alcohol to help me cope with the difficulty times in my life, as my problems bring me down all the time' (Alexi).

Exposing these aspects of experiential knowledge provided participants' with the ability to view causal mechanisms and consequences of individual behaviour as an organic and incremental process of change. Participants' accumulated an array of negative experiences in relation to their co-morbid condition, often resulting in a variety of maladaptive developmental responses. However, participants attempted to make sense of their maladaptive behaviour and complex case histories;

'Drinking is the thing that I use to help me with my bad experiences and anxiety over time. The way I feel has never stayed the same, it just depended on the bad circumstances which have affected me over the years at given points in time' (Spencer).

For Review Only

Participants' ability to interact with their social environment was a crucial factor in acknowledging and redefining their dual disorder in the context of their dependent behavioural patterns.

Levels of knowledge

This theme revealed a number of gaps in participants' level of knowledge of how to manage their substance misuse effectively. Participant's reported, for example, stimulant drug use as a means to address symptoms of mood disturbance without taking into account the consequences of associated rebound effects. However, the short and long-term effects of substance misuse resulted in a range of unpleasant emotional and psychological experiences such as anxiety, exhaustion; problems with volition, motivation and paranoia. Participants described their limited understanding concerning the consequences of their substance misuse and the interactive effects of their prescribed medication;

'I did not know that alcohol had such a massive depressing effect on my mental health, especially as I thought the prescribed antidepressant from my doctor was helping me cope with my mood' (Gary).

This dual conflict of independence versus dependence was common place and demonstrated a dichotomy between the needs of the individual and the treatment perspective; traditionally based on prescriptive models of practice (NICE, 2016). Participants' expressed a degree of uncertainty concerning the longitudinal negative effects of their substance misuse and described their ongoing relationship with drugs as a form of personal reassurance and affiliation with a familiar behaviour (Cassidy et al., 2013). This comprised of personal levels of attachment by participants' via cyclical and reinforcing methods of substance misuse. Some described their ongoing

For Review Only

relationship with substance misuse as if it were a co-dependent emotional attachment, dysfunctional in nature, often associated with the ebb and flow of the tide (Buchanan-Barker and Barker, 2008);

'I think at times my drug use changed week on week and it is just like kicking the cat which stirs up so many emotions in a very unstable way. The group helped me make sense of some of these emotions' (Emily).

'The group made sense because it combined useful information about mental health and substance misuse. It was done in a way that made me feel supported' (Stacey).

Getting started on alcohol and drugs

This theme explained the complex factors associated with commencing substance misuse. Traumatic or stressful life events were commonly cited as a precursor to drug use, contributing to individuals becoming increasingly vulnerable and experiencing long-term comorbidity (Chartier et al., 2009). The repeated misuse of illicit substances in response to environmental stressors and increasing levels of vulnerability, revealed a pattern of escalating drug use;

'There were a number of circumstances that contributed to my drinking behaviour. I started drinking at 12 and then I lost my brother in a car accident and things just got worse' (David)

For some participants the description of trauma related to experiences in early childhood was related to a marked decline in their mental well-being and quality of life which was manifest in a variety of mental health symptoms and maladaptive addictive behaviours (Romme and Escher, 2013);

For Review Only

'I was always having strange dreams regarding my abusive childhood. It got to the stage when I was drinking heavily, and the voices became really loud and negative and I got worse mentally. But it got to the stage when the voices were just there all the time telling me I was to blame no matter what I did and this just made me drink even more' (Greg;).

The implication of such psychopathology was dependent on some participant's individual circumstances and social learning experiences. Many participants' started consuming drugs and alcohol at a young age, resulting in some participants escalating from occasional use to more problematic dependency and tolerance to stronger drugs (Zernig et al., 2013). For many participants this engendered a sense of helplessness and hopelessness, typically reinforced by poor and dysfunctional social networks, often leading to chronic periods of social isolation, stigma and depersonalisation.

Impact of Condition on Behaviour and Lifestyle

This theme explains participants' aspiring to change aspects of their behaviour and lifestyle along with personal insight regarding the negative impact substance misuse played in their lives;

'I was taking too many drugs which made me unhappy and paranoid. I did a lot of stupid things. I did not talk to many people, keeping myself to myself. I could just not understand why I was seeing people in the way I was, and hurting people who were close to me. My life did not make much sense and I struggled for years' (Stuart).

For Review Only

For some participants' there was a sense that something could be done to suspend or reverse the consequences of their maladaptive behaviour by acknowledging the beneficial component of peer support and engaging in the treatment process;

'My drug use was a big problem and I just wanted to get more control in my life and that is why I wanted to speak to other users in the group therapy who understood my problem. By being with others in the group who understood my problem it helped feel safe and think about my own situation and how it affected my relationship with my family and especially my daughter' (Will).

However, treatment did not necessarily result in positive change or perceived social benefits. It was acknowledged that sometimes it can be difficult to socialise with others, being caught up in a duality of despair, often resulting in social isolation, dysfunctional relationships, and ongoing poor engagement with mental health services reinforced over many years (Drake et al., 2006).

Motivation to Change

This theme included a focus upon taking action to change behaviour. Change was supported by motivation, which manifested in individual actions orientated towards modifying maladaptive and harmful behaviours. However, it was clear that some participants were at different stages in their recovery journeys, with a sense of hopefulness being a central component to the treatment process (Bonney and Stickley, 2008)

'There is a huge link regarding my mental health and drug use. I have been thinking about changing my life around for a long time. Coming to the group allowed me to make a positive jump forward. But you need the right kind of help and the right kind of information to make meaningful changes' (Stacey).

For Review Only

Some participants displayed a level of self-awareness and readiness to change that resonated in their experience of the treatment process. Consolidating and maintaining changes was an important consideration acknowledged by participants. This factor is relevant as stages of motivation often comprise of cyclical episodes of relapse and remission (Kazdin, 2009). Participants demonstrated elevated levels of motivation which often emerged after considerable self-reflection reinforcing individual's ability to consolidate positive and meaningful change;

'I am more aware, because we talked about taking control in the group and looking back I think I was planning things in my life but I just was not aware of it. The ability to think positively about change with others in the group gave me the confidence to consider moving forward' (Lara).

Many participants' regardless of their level of motivation required meaningful and cohesive support. The level of self-perception concerning social support with other people with the same sort of problem encapsulated collective, not singular social intervention. Consequently, the process of motivation to change resulted in, and their constant struggle for, control of their condition;

'I was not sure about the group and how motivated I was to work with others in the group. I am still using drugs and will not stop, but it did make me think about the risks and harm in my life. Drug use is risky and many of my mates have died using drugs' (Gary).

Struggle for Control of Treatment

This theme explored the myriad of challenges faced by participants' in relation to their treatment and the level of autonomy they experienced as recipients of mental health service provision. Prescribed psychiatric medication management was referred to frequently, with a variety of

For Review Only

views being stated concerning the efficacy of treatment. Causal mechanisms and poor standard treatment outcomes were frequently highlighted as primary reasons for participants' continuing to use illicit substances. The medical model (Hirschkorn and Bourgeault, 2007) was also deemed limited in its prescriptive scope and level of effectiveness to deal with participants' complex needs. Many participants' experienced challenges in self-managing and self-regulating their prescribed psychiatric drug treatment;

'I am on prescribed medication from the doctor, but I still have problems with voices and many side-effects of the medication like twitches and muscle stiffness. I have used a bit of cannabis to help with some of the side-effects, but I have not told the consultant psychiatrist because he would not understand' (Gary).

The struggle for control of the treatment process by participants was conceptualised as an ongoing dialogue with treatment services to reduce the perceived negative impact of specific treatments. All participants' were being prescribed psychiatric medication as part of their ongoing mental health condition, and were expressed in association with attempting to self-manage their prescribed medication and illicit substance misuse;

'The new mental health drug kind of helps my hearing voices, but it does make me very drowsy. When I have taken heroin and in the past many of my voices do go away but it can cause problems with my prescribed treatment. It can be a double bind at times' (Tony).

Communication with Others

For Review Only

Some participants' described the inclusive treatment process as a means of amplifying a sense of humility and empathy (Barker and Buchanan-Barker, 2004). Thus enabling active engagement with other group members, directly placing responsibility for their interaction to change their behaviour within the sphere of their control;

'I think sharing experiences with others was really important. If you talk to people you can have a sort of conversation and you bond with them. It can give you a sense of belonging and feeling normal because they understand where you are coming from. I also think it is the help you get through communication with others that really counts' (Kay).

Group members shared similar problems with each other, and were able to help one another, on the same level, i.e. peer to peer. Some participants recognised their own emotional state and that of others in the group, enabling them to value and validate fellow members within a process of reciprocity and reflect on the importance of past experiences.

'The group was the only therapy which supported my needs because it helped me feel normal and I was able to speak out with a voice' (Margarete).

The interpersonal and cohesive structure of the group programme was directly linked to individual perception and a sense of belonging and needing to affiliate of members to a supportive treatment intervention that validated the individual and the collective experience.

Participants' stressed the importance of effective communication and connecting with others. However, for some the treatment process identifies some challenges in forming and maintaining meaningful social relationships, generally;

For Review Only

'I have been blamed for my drug use ever since I was in my adolescence. You might say that I have deserved it. But it is just how my life has been which makes it difficult to connect' (Jacob).

The level of personal distress and the importance of personal attributes, such as trust and honesty, were perceived as important when forming beneficial relationships within a social context (Link and Phelan, 2013).

Sense of Belonging

This theme reflected the essence of the therapeutic group intervention and the opportunity it provided for participants to interact successfully with other group members; reinforcing a sense of self-identity and belonging to the treatment intervention. Participation itself and appreciation of being accepted unconditionally by other group members, with similar co-occurring conditions, had a regulatory effect on their negative experiences. This in turn supported some individuals to externalise the maladaptive characteristics of their behaviour and contextual perspectives of the treatment process;

'I have been in and out of treatment for years being passed from one service to another. The group helped me work through my problems and I felt accepted and part of something worthwhile and I felt accepted and part of something whole' (Stuart).

Participants stated they valued the experience of social inclusion and participation in the decision-making process concerning their health care provision which contrasted with their pervading sense of social exclusion and perceived stigma from mental health services and society at large, which they had endured over many years;

For Review Only

'I have experienced a lot of negative attitudes by other people over many years, who have blamed me for things that were not my fault, often not knowing who I was as a person or taking the time to ask' (Robert).

'Because we had similar problems and backgrounds in the group I felt more confident to express my-self and because we all had something wrong with us it kind of made us stronger in a strange way' (Lara).

The findings of the study suggest that providing integrated treatment for mental health and substance misuse through the use of PEG therapy proved beneficial across both dimensions of problems presented by people with dual diagnosis. Importantly, participants' reported finding the formation of meaningful therapeutic relationships within the group to be an important factor in their experiences. The idiosyncratic nature of these relationships has been characterised as a means of countering a range of distressing and incompatible environmental and situational stressors, such as poor levels of symptom control and social anxiety (Chaplin et al., 2008). The importance of developing a sense of balance and perspective by participants' in PEG therapy was considered crucial to reducing participants' situational stressors and negative social influences consistent with poor service fidelity, high levels of relapse, stigma and escalating levels of social neglect and conflict (Walker et al., 2013).

Participants' reported finding the integration of treatment to be beneficial in reducing the sense of stigma and exclusion linked with using mental health services (Minkoff, 2013). Effective treatment plans need to address the role played by single treatment delivery systems, and the effective application of holistic treatment approaches need to be considered an important aspect

For Review Only

of treatment for individuals with complex comorbid conditions (NICE, 2016). It is important to highlight that although the conclusions from this study cannot be generalised, the findings have provided important insights into the therapeutic process through the consideration of the complex interactions of service user experience and the curative dynamics of the treatment process.

The study had a number of limitations. For example, the term dual diagnosis is broad and non-specific, and whilst it is used frequently to describe a service user group, it is of little value when tailoring individual care or treatment. There is a danger of contributing to the homogenising effect through the use of this label. In terms of participants, the study was constrained by a possible a self-selection bias in the participant sample and the applied, in-practice nature of the study design.

Relevance to clinical practice

Integrated treatment for dual diagnosis, where the mental illness and the substance use disorder are treated simultaneously, is a developing approach in clinical care. This study provides further insight into the efficacy of such approaches by providing qualitative findings to complement the existing, yet sparse, evidence base. Understanding the dynamics of these treatment approaches, such as the important role of social integration and the provision of a social network for discussions with similar others, are useful factors for health care professionals to consider in the future design and delivery of treatment for dual diagnosis.

For Review Only

References

Barker, P. J. & Buchanan-Barker, P. (2004). *The Tidal Model: A guide for mental health professionals*: Routledge.

Barrowclough, C., Haddock, G., Wykes, T., et al. (2010). Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: randomised controlled trial. *BMJ,* 341**,** c6325.

Bazeley, P. & Jackson, K. (2013). *Qualitative data analysis with NVivo*: Sage Publications Limited.

Bonney, S. & Stickley, T. (2008). Recovery and mental health: a review of the British literature. *Journal of psychiatric and mental health nursing,* 15**,** 140-153.

Buchanan-Barker, P. & Barker, P. (2008). The Tidal Commitments: extending the value base of mental health recovery. *Journal of Psychiatric Mental Health Nursing,* 15**,** 93-100.

Cassidy, J., Jones, J. D. & Shaver, P. R. (2013). Contributions of attachment theory and research: A framework for future research, translation, and policy. *Development and psychopathology,* 25**,** 1415-1434.

Chaplin, T. M., Hong, K., Bergquist, K. & Sinha, R. (2008). Gender differences in response to emotional stress: an assessment across subjective, behavioral, and physiological domains and relations to alcohol craving. *Alcoholism: Clinical Experimental Research,* 32**,** 1242-1250.

Chartier, M. J., Walker, J. R. & Naimark, B. (2009). Health risk behaviors and mental health problems as mediators of the relationship between childhood abuse and adult health. *American Journal of Public Health,* 99**,** 847-854.

Chilton, J., Crone, D. & Tyson, P. (2018). Clinical Outcomes From a 10-Week Follow-Up Psychoeducational Program for Dual Diagnosis. *Journal of dual diagnosis***,** 1-9.

Cleary, M., Hunt, G. E., Matheson, S., Siegfried, N. & Walter, G. (2008). Psychosocial treatment programs for people with both severe mental illness and substance misuse. *Schizophrenia Bulletin,* 34**,** 226-228.

Derry, A. (2008). The clinical response to substance use problems in forensic mental health services. *British Journal of Forensic Practice,* 10**,** 20-23.

Drake, R. E., Becker, D. R., Goldman, H. H. & Martinez, R. A. (2006). Best practices: The Johnson & Johnson—Dartmouth community mental health program: Disseminating evidence-based practice. *Psychiatric Services,* 57**,** 302-304.

Gobbart, S. (2013). 'Changing habits': An evaluation of a dual diagnosis focused, integrated, multimodal, psychosocial education and skill building group programme delivered in a community-based setting. *Mental Health and Substance Use,* 6**,** 29-46.

Hirschkorn, K. & Bourgeault, I. (2007). Actions speak louder than words: mainstream health providers' definitions and behaviour regarding complementary and alternative medicine. *Complementary therapies in clinical practice,* 13**,** 29-37.

Kay-Lambkin, F. J., Baker, A. L., Lewin, T. J. & Carr, V. J. (2009). Computer-based psychological treatment for comorbid depression and problematic alcohol and/or cannabis use: a randomized controlled trial of clinical efficacy. *Addiction,* 104**,** 378-388.

Kazdin, A. E. (2009). Understanding how and why psychotherapy leads to change. *Psychotherapy research,* 19**,** 418-428.

Khantzian, E. J. (1987). The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *The cocaine crisis.* pp. 65-74). Springer.

Lefcourt, H. M. (2014). *Locus of control: Current trends in theory & research*: Psychology Press.

For Review Only

Link, B. G. & Phelan, J. C. (2013). Labeling and stigma. *Handbook of the sociology of mental health.* pp. 525-541). Springer.

Miller, W. R. & Rollnick, S. (2012). *Motivational interviewing: Helping people change*: Guilford press.

Minkoff, K. (2013). Treating Comorbid Psychiatric and Substance Use Disorders. *Psychiatric Times,* 30**,** 13-13.

Morgan, S. & Carson, J. (2009). The Recovery Group: A service user and professional perspective. *Group-work,* 19**,** 26-39.

NICE (2016). Coexisting severe mental illness and substance misuse: community health and social care services. London: National Institute for Health and Clinical Excellence.

NMC (2018). The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associate. London: Nursing and Midwifery Council.

Parrish, M. (2014). *Social work perspectives on human behaviour*: McGraw-Hill Education (UK).

Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers. London: PHE.

Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience: An introduction to interpretative phenomenological analysis. The Psychologist, 18 (1), 20-23.

Romme, M. & Escher, S. (2013). *Psychosis as a personal crisis: An experience-based approach*: Routledge.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review,* 5**,** 9-27.

Taylor, K. W. & Kliewer, W. (2006). Violence exposure and early adolescent alcohol use: An exploratory study of family risk and protective factors. *Journal of Child Family Studies,* 15**,** 201-215.

Walker, H., Tulloch, L., Ramm, M., et al. (2013). A randomised controlled trial to explore insight into psychosis; effects of a psychoeducation programme on insight in a forensic population. 24**,** 756-771.

Zernig, G., Kummer, K. K. & Prast, J. M. (2013). Dyadic social interaction as an alternative reward to cocaine. *Frontiers in psychiatry,* 4**,** 100.

For Review Only